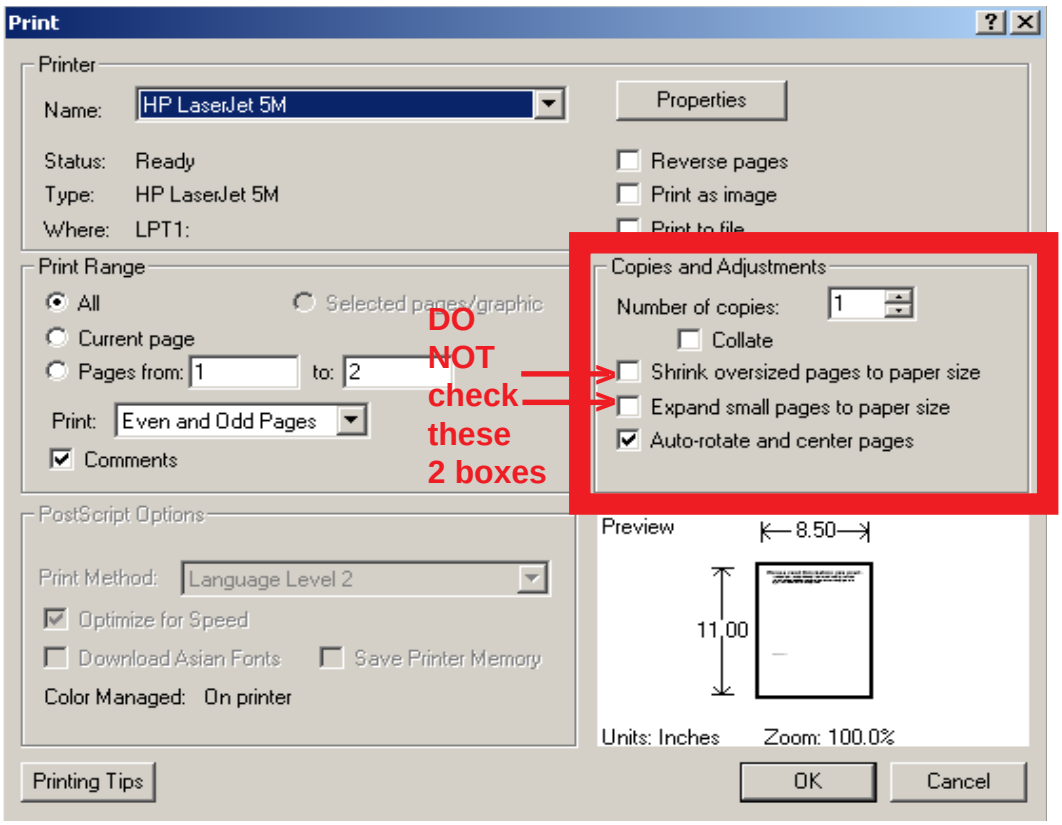
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Certified Social Worker License Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Certified Social Worker License

DEPOSIT SLIP

NAME (PLEASE PRINT)

DATE

DOH 670-085 (8/2003)

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

1F 0207040000 00215

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Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

Instructions
Application for
Certified Social Worker License

Application Fee **$25.00**

Initial Licensure Fee **$25.00**

All Fees are Non-refundable

Department of Health
Counselor Programs
PO Box 1099
Olympia, WA 98504-1099

If you are sending supporting documents separate from the four-page application form, please mail to the following address:

Department of Health
Counselor Programs
PO Box 47869
Olympia, WA 98504-7869

Please indicate whether you are applying for advanced or independent clinical social worker licensure. The department will process your application as an advanced social worker if you fail to mark the appropriate box on the application.

1. **Demographic Information**

   Please complete the application form. To assure appropriate review, all information should be typed or printed clearly. Applications cannot be processed without a birth date and social security number. A resume will ***not*** substitute for completion of the application. It is the applicant's responsibility to keep the Department of Health, Counselor Programs, informed of any address change.

2. **Previous Certification/Licensure/Registration**

   List all states in which you now hold or have held a certification, license, or registration to practice as a Social Worker or any other professional certification, license, or registration. Also, include those states in which you may have applied and a certification, license, or registration was not granted. Please include an explanation. Please send the **Out-of-state Verification Form** to each state in which you have held a Social Worker certification, license, or registration, even if it has now expired. This form may be duplicated.

3. **Examination Data**

   ASWB's advanced or clinical is acceptable for licensure in Washington State. If you did not take either the advanced or clinical ASWB examination, you will be required to take the examination to obtain licensure. If you have taken the required examination (advanced or clinical), the state in which you took the examination must verify the score. If the state in which you took the examination does not verify the score, you will then need to obtain written verification from the testing company that administered the examination.

4. **Personal Data Questions**

   If any questions on the Personal Data page have a "Yes" response, the supporting documents and explanation required for that answer must be attached.

5. **Education**

   Graduation from a master's or doctorate social work educational program accredited by the council on social work education, is required. Request an official copy of your master's degree transcripts from the graduate school granting the degree. Transcripts must be mailed directly to the department from the school.

6. **Aids Education And Training Attestation**

   Please read carefully the AIDS education and training attestation. After you have completed a minimum of 4 hours of AIDS education, sign and date the attestation.

6. **Applicant's Attestation**

   After you have familiarized yourself with the statutes cited in your licensure law, sign and date the attestation.

Experience Requirement

Licensed Advanced Social Worker:

Minimum of **three thousand two hundred hours** with **ninety hours** of supervision by a licensed independent clinical social worker or a licensed advanced social worker who has been licensed or certified for at least two years. Of those hours, **fifty hours** must include direct supervision by a licensed advanced social worker or licensed independent clinical social worker; the other **forty hours** may be with an equally qualified licensed mental health practitioner. **Forty hours** must be in one-to-one supervision and **fifty hours** may be in one-to-one supervision or group supervision. Distance supervision is limited to **forty** supervision hours. **Eight hundred hours** must be direct client contact.

Licensed Independent Clinical Social Worker:

Minimum of **four thousand hours** of experience, of which **one thousand hours** must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least **one hundred thirty hours** by a licensed mental health practitioner. Of the total supervision, **seventy hours** must be with an independent clinical social worker; the other **sixty hours** may be with an equally qualified licensed mental health practitioner. **Sixty hours** must be in one-to-one supervision and **seventy hours** may be in one-to-one supervision or group supervision. Distance supervision is limited to **sixty** supervision hours.

Out-of-state Verification Form

This form is required if you hold or have held a certification, license, or registration to practice as a Social Worker or any other professional certification, license, or registration.

Examination Information

Once you have been approved to take the examination, you will be sent an approval letter. This letter gives you further information on how to register for the examination. You will be taking the examination directly from the American Association of Social Work Boards (**ASWB**).

The Department receives score reports within 6 weeks of administration from the testing company. Once you have completed all the requirements and have passed the **ASWB** advanced or clinical examination and the $25 initial licensure fee has been received, licensure will be granted.

OR

If an examination is not required and all other requirements have been met, including the $25 initial licensure fee, licensure will be granted.

Washington State Department of Health
Health Professions Quality Assurance
Counselors Programs
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
LICENSE NO:	LICENSE DATE:
APPROVED BY:	
VALIDATION INFORMATION:	

LICENSE #

Application for Social Worker License

Check only one: ☐ Advanced ☐ Independent Clinical

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE INITIAL

MAILING ADDRESS

CITY | STATE | ZIP | COUNTY

Note: Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us of a change.

BUSINESS TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS)

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)

GENDER ☐ Female ☐ Male

BIRTHDATE

PLACE OF BIRTH

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, other name(s):

2. Previous Certification/Licensure/Registration

List **all** states (including Washington) where certifications/licenses/registrations are or were held. Specifically list certifications/licenses/registrations granted by examination, endorsement, or grandparenting.

STATE	CERTIFICATION/LICENSE TYPE	License/Registration/Certification		METHOD OF LICENSURE		
		YEAR ISSUED	NUMBER	EXAM	END	GP

An "Out of State Verification for Registration/Certification/Licensure" form is enclosed and must be sent to each state listed above. Enter your full name and birthdate at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

3. Examination Data

Have you taken and passed the Association of Social Work Boards (ASWB) advanced or clinical level exam?

☐ Yes ☐ No

☐ Advanced Level ☐ Clinical Level

4. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

5. Education

Please provide a chronological listing of graduate school(s) attended, major, and month and year the degree was granted. A transcript is to be requested from the graduate school(s) and sent **directly** from the graduate school to the Department of Health, Social Worker Licensure Section per instructions.

GRADUATE SCHOOL	DEGREE AND MAJOR	DEGREE GRANTED	
		MONTH	YEAR

6. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

7. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

Signature of Applicant _____ Date _____

Official Use Only

Washington State Records Center

Washington State Department of Health

Verification of Social Work Supervised Postgraduate Experience

Licensed Advanced Social Work (LASW) means the application of social work theory and methods including emotional and biopsychosocial assessment, psychotherapy under the supervision of a licensed independent clinical social worker, case management, consultation, advocacy, counseling, and community organization.

LASW will only allow you to practice under supervision and is designed for people working in agencies, hospitals, schools, etc. If you choose to become LASW, you will have to reapply to become an LICSW if you practice under the definition of an LICSW in the future.

Licensed Independent Clinical Social Work (LICSW) means the diagnosis and treatment of emotional and mental disorders based on knowledge of human development, the causation and treatment of psychopathology, psychotherapeutic treatment practices, and social work practice as defined in advanced social work. Treatment modalities include but are not limited to diagnosis and treatment of individuals, couples, families, groups, or organizations.

LICSW will allow you to practice independently or in an agency setting.

Applicant:

Use a separate form for each supervisor verifying your postgraduate supervision and professional experience for each practice setting. This form may be duplicated. Fill in Section 1 and forward the verification form to the supervisor for completion.

1. Print or Type Clearly:

NAME LAST	FIRST	MIDDLE	BIRTH DATE
ADDRESS			
CITY	STATE		ZIP

2. Postgraduate Supervised Experience for **Advanced Social Worker:**

Applicants must have a minimum of **twenty-four months** of postgraduate experience and **three thousand two hundred hours** with **ninety hours** of supervision by a licensed independent clinical social worker or a licensed advanced social worker who has been licensed or certified for at least two years. Of those hours, fifty hours must include direct supervision by a licensed advanced social worker or licensed independent clinical social worker; the other forty hours may be with an equally qualified licensed mental health practitioner. Distance supervision is limited to forty supervision hours.

Months of Supervision

From: / /	To: / /
MO DAY YR	MO DAY YR

Indicate the number of hours of direct client contact **(800 hours required)** ..... _____

Indicate the number of hours of one-on-one or group supervision **(50 hours required)** ..... _____

Indicate the number of hours of one-on-one supervision **(40 hours required)** ..... _____

Total Number Of Hours (3,200 hours required) ..... _____

3. Postgraduate Supervised Experience for **Independent Clinical Social Worker:**

Applicants must have a minimum of **four thousand hours** of experience and three-year period supervised by a licensed independent clinical social worker, with supervision of at least **one hundred thirty hours** by a licensed mental health practitioner. Of the total supervision, seventy hours must be with an independent clinical social worker; the other sixty hours may be with an equally qualified licensed mental health practitioner. Distance supervision is limited to sixty supervision hours.

Months of Supervision

From: / /	To: / /
MO DAY YR	MO DAY YR

Indicate the number of hours of direct client contact **(1,000 hours required)** ..... _____

Indicate the number of hours of one-on-one supervision **(60 hours required)** ..... _____

Indicate the number of hours of one-on-one or group supervision **(70 hours required)** ..... _____

Total Number Of Hours (4,000 hours required) ..... _____

4. Supervisor:

The above individual seeks licensure as an Advanced Social Worker or Independent Clinical Social Worker in Washington and requires verification of postgraduate supervision and postgraduate professional experience. Please complete the following:

SUPERVISOR NAME		CURRENT PHONE
CURRENT STREET ADDRESS		
CITY	STATE	ZIP

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the department may request additional information, if it is needed, to evaluate the application of the individual named on this document.

SIGNATURE

DATE

Return this form to: **Department of Health**
Social Worker Licensure
PO Box 47869
Olympia, WA 98504-7869

Washington State Department of Health

Out of State Verification of Registration / Certification / Licensure As A Social Worker

Applicant Name: _____ Birthdate: _____

I, _____ , Secretary of _____ ,
OFFICIAL NAME OF BOARD

hereby certify that _____

was granted state: ☐ Registration ☐ Certificate ☐ License Number _____ to practice _____

in the State of _____ on the _____ day of _____ , 20 _____.

Legal/Disciplinary Action: ☐ Yes ☐ No

If Yes, explain: _____

_____

On the basis of:
- ☐ Successfully passing the Association of Social Worker Boards ☐ Advanced or ☐ Clinical exam Enter Score: _____
- ☐ Successfully passing the required state constructed exam
- ☐ Grandfathered
- ☐ Other (Explain) _____

Requirements at the time of ☐ Licensure, ☐ Certification, or ☐ Registration

_____

_____

_____

Status of License: ☐ Current ☐ Expired Expiration Date: _____

S E A L

Acting In Behalf Of The:

_____
OFFICIAL NAME OF BOARD PHONE

Return to:

Department of Health
Social Worker Licensure
PO Box 47869
Olympia, WA 98504-7869

_____
SECRETARY

_____
DATE CERTIFICATION PREPARED